CONTRACTING FOR THE DELIVERY OF PRIMARY HEALTH CARE IN CAMBODIA: DESIGN AND INITIAL EXPERIENCE OF A LARGE PILOT-TEST

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SUMMARY:

Despite the potential benefits of contracting with the private sector for delivery of publicly-financed health services, its effectiveness and efficiency has rarely been evaluated. This paper describes the design and early implementation experience of a project in Cambodia that is pilot-testing contracting with non-governmental organizations (NGOs) for the delivery of primary health care on a large scale. Three approaches are assessed: Contracting out (CO) in which contractors have complete authority for hiring, firing, and paying staff as well as procuring drugs and supplies; Contracting in (CI) where contractors provide management services within the existing district health structure; and comparison/control (CC) where the existing district health management teams receive a budget supplement (as do CI districts).

I: INTRODUCTION

1. There is increasing interest in developing countries in contracting with NGOs and the for-profit private sector to deliver health services, particularly primary health care (PHC). Much of the impetus for contracting has arisen from a perception that publicly provided health services are not particularly effective or efficient. Experience from other sectors in developing countries (1) and from the health sector in developed countries (2) has also contributed to the increased interest in contracting for the provision of PHC. Contracting for services is attractive because it has the potential to:
   • Ensure a greater focus on the achievement of measurable results, particularly if contracts define objectively verifiable outputs and outcomes;
   • Utilize the private sector’s greater flexibility and generally better morale to improve services and responsiveness to consumers;
   • Increase managerial autonomy and decentralize decision making to managers on the ground;
   • Use competition to increase effectiveness and efficiency; and
   • Allow governments to focus less on service delivery and more on other roles which they are uniquely placed to carry out, such as planning, standard setting, financing, and regulation.

2. Despite its potential, there have been few evaluations of how well contracting for health services works in practice in developing countries (3,4). There are concerns that contracting may have high transaction costs, overwhelm government’s capacity to draft, manage, and monitor the contracts, and be significantly more expensive than public
provision of services. This paper describes the design and early experience of a project in Cambodia that is pilot testing contracting for PHC services on a large scale.

II. BACKGROUND

3. Many years of war and political upheaval have left Cambodia with a limited health infrastructure, particularly in rural areas. While there are sufficient paramedical staff, their training is inconsistent and quality of care remains low. The morale of health workers is poor as salaries in the public sector are very low (about $8 to $15 per month at current exchange rates) and most are involved in some form of private practice. Often poor quality management at the district level, which has resulted from the appointment of managers on the basis of political connections rather than demonstrated ability, exacerbates the low morale of the workers. All these issues have resulted in a PHC system that has not been able to deliver an adequate level of services. For example, a 1998 demographic and health survey found that, nation-wide, only 39% of children 12-23 months of age were fully immunized.

4. To address these serious issues, the Ministry of Health (MOH) devised a “coverage plan” to restructure and broaden the PHC system. This involved the construction or rehabilitation of health centers each designed to provide services to about 10,000 population. It also involved merging smaller administrative districts into “operational districts” with a population of about 150,000. The coverage plan defined a minimum package of services and activities (MPA) that would be carried out at health center level. The MPA consisted of basic preventive and curative services such as immunization, family planning, antenatal care, provision of micronutrients and other nutritional support, and simple curative care for diarrhea, acute respiratory tract infections, and tuberculosis.

5. The Royal Government of Cambodia obtained a loan from the Asian Development Bank to help implement the coverage plan. The loan was also used to test the effectiveness and efficiency of contracting with NGOs and the private sector for the delivery of PHC services. It was felt that involving the private sector was justified as a way of quickly improving services, managing the transition to the coverage plan, and making up for weak district level management. Twelve districts with populations ranging from 100,000 to 180,000 were selected for the pilot test and three approaches were devised:

- **Contracting Out (CO):** in which the contractors have complete line responsibility for service delivery, including hiring, firing and setting wages, procuring and distributing essential drugs and supplies, organizing and staffing health facilities;

- **Contracting In (CI):** where the contractors work within the MOH system and have to strengthen the existing district structure. The contractors cannot hire or fire district health workers, although they can request their transfer. Drugs and supplies are provided to the district through the normal MOH channels. The contractor receives a budget supplement of $0.25 per capita per year to spend on incentives for staff, operating expenses, etc. For a typical district this amounts to about $37,000 per year.

- **Control/Comparison (CC):** in which the management of services remains in the hands of the District Health Management Team (DHMT) and drugs and supplies
continue to be provided through normal MOH channels. As with the CI, the DHMT receives a budget supplement of $0.25 per capita per year to spend on incentives for staff, operating expenses, etc.

III. DESIGN AND TENDERING PROCESS

6. During the design and implementation of the project there were extensive discussions between the MOH, NGOs, and other stakeholders about how the contracting process should be implemented. A committee was established within the MOH to oversee the pilot test, chaired by the Director General, Health Services. An independent group conducted baseline household surveys comprising about 450 households in each of the 12 pilot districts. Baseline health facility surveys to assess quality of care were also carried out in the pilot area. The districts were then randomly assigned to CO, CI, or CC. The household and health facility surveys will be repeated in mid-2001 and towards the end of the contract period. Hence, initial evaluation results should be available by the end of 2001.

7. Tender documents, including a formal contract, were developed by the MOH, a consultant, and the Asian Development Bank and stipulated the responsibilities of the contractors and the MOH. Under both CO and CI, contractors are expected to deliver the MPA and explicit targets have been established for specific services. For example, immunization coverage is expected to improve to 70%, antenatal care coverage to 50%, and knowledge of at least three methods of family planning to 70%. In addition to the MPA, contractors are also expected to operate the district hospital and provide a series of complimentary services, such as emergency obstetrical care, minor surgery, and in-patient treatment of more serious illnesses.

8. Achievements on the parameters listed above and other parameters, including some related to quality of care, have been incorporated into an overall performance score. Bidders had to specify in their proposals the mechanisms they would use to ensure quality of care in health centers and hospitals. To ensure that contractors are reaching the poorest segments of their catchment population, indicators are also included in the overall performance score that reflect the coverage of services among the poorest 50% of the community (as judged by the quality of housing observed during the household survey).

9. In the districts under the CO contract the MOH is obliged to provide the contractors with health facilities, equipment, access to its training courses, technical guidelines, and a list of all personnel working in the district. In the CI districts, the MOH is also obliged to provide drugs and supplies. Contractors are allowed to introduce user charges within explicit MOH guidelines. Contractors have to maintain clear accounts and are obliged to provide the MOH with financial reports in addition to standard health management information system reports on activities. The MOH can supervise the contractors’ health centers and hospitals at any time during the life of the contract and have been doing this type of monitoring regularly using a standard checklist. Each contract is of 4 years duration and has explicit terms for termination by the client or the contractor.

10. An international competitive bidding process was used to select contractors after advertising in the international press and sending of letters to consulting firms registered
with the Asian Development Bank. A “two envelope” system comprising separate technical and financial proposals was employed for evaluating bids. The technical proposals of the bidders were judged on the basis of the senior personnel nominated, the experience of the NGO/firm, and a plan of action for delivering services. A committee comprising representatives of the MOH, the World Health Organization, and Medicam, an association of NGOs working in the health sector in Cambodia conducted the evaluation. The financial proposals of technically responsive bidders were opened publicly and a score was calculated incorporating both cost and the quality of the technical proposal.

IV. RESULTS OF BIDDING AND EARLY IMPLEMENTATION EXPERIENCE

11. There were expressions of interest received from 51 organizations, including 36 from outside Cambodia, and tender documents were purchased for a $50 fee by 20 different organizations. A total of 16 bids were submitted for the 8 available contracts coming from 10 bidders (bidders were able to apply for more than one contract). The 10 bidders represented 14 different organizations, as some bids came from partnerships among different organizations. Of the 14 organizations involved in the bidding process, 8 were NGOs working in Cambodia, 4 were consulting firms, and 2 were university-affiliated groups. Informal discussions with the organizations which purchased tender documents but who did not subsequently submit bids, indicated that there was concern about the broad scope of work, possibly difficult relations with MOH staff and local politicians, financial risks firms would take in bidding because the contracts were fixed price, and the perceived political instability of the government.

12. At least 2 bids were submitted in all but 2 of the districts being contracted. Out of the 16 bids received, 8 technical proposals were judged by the evaluation committee to be “non-responsive” (i.e. they did not meet the minimum technical criteria specified in the bid documents and had a technical “score” below an established cut-off point). This left 2 districts without technically responsive bids. In another district the financial proposals of the two technically responsive bidders were judged by the MOH to be too expensive as they would cost $10.65 and $13.50 per capita per year. By comparison the MOH’s total annual budget is about $2 per capita.

13. The average bid price for CO was $5.04 per capita per year and the average bid price for CI was $1.54 per capita per year, however that latter price did NOT include salaries, drugs and supplies, and other operating costs that come out of the MOH budget. When these costs are included, the total cost of CI is about $2.50 per capita per year, or about half of the price of CO. All the winning bidders were international NGOs with previous experience working in Cambodia and one of the NGOs won two contracts.
14. As described in the figure below, the bidding process resulted in: (i) CO being implemented in 2 districts; (ii) CI being implemented in 3 districts; (iii) 4 comparison/control districts (CC1) will receive budget supplements; and (iv) 3 comparison/control districts (CC2) will not receive budget supplements. The follow-up household and health facility surveys will provide information on the effectiveness and efficiency of the different approaches and allow 3 sets of comparisons. The comparison between the CO and CI districts will help assess the importance of greater management autonomy and higher salaries for health workers on performance. It will also help determine whether the higher cost of CO is warranted. The comparison between CI and the comparison/control districts that receive budget supplements (CC1) will measure the effectiveness of private sector management in a setting where resource availability is approximately equivalent. The comparison between CC1 and CC2 will gauge the importance of budget supplements on performance.

Figure 1: Experimental Design & Significance of Comparisons

- **CO** = 2 districts
- **CI** = 3 districts
- **CC(1)** = 4 districts
- **CC(2)** = 3 districts

15. The contracts with the NGOs were signed in December 1998 and it took until March 1999 for contractors to establish a field presence in their districts. In both CI and CO districts, the contractors have been paid on time and have submitted the required reports promptly. There appears to have been little progress made in improving service delivery in the comparison/control districts, CC1 or CC2.
16. In CO districts improvements in service delivery became evident quite quickly. Supervisory visits and some data from the health management information system suggest that coverage levels, such as the immunization coverage rates and the proportion of women receiving prenatal care, are beginning to improve. Staff come to work regularly, partly as a result of increased salaries and partly because of better management and supervision. Although they were under no such obligation, contractors in contracted out districts hired most of the paramedical staff working there and paid them up to 10 times more than their government salaries (i.e. $70-$125 per month). Hence, the difference in cost between CO and CI reflects increased salaries paid to staff. In order to work for a contractor, MOH staff have had to take leaves of absence from their government jobs which most of them have done without much thought.

17. In the CI districts progress has not been as rapid although there does appear to be some improvement in service delivery. The relationship between contractor and MOH staff is less clear and it has taken longer to implement changes. Staff do not yet see much benefit from the contract although they have received some incentive payments coming from the budget supplements and user charges. Staff have expressed concerns that contractors’ expectations will interfere with the time they have available to earn money from private practice. In addition, some senior district staff have requested transfers to other districts. In one of the CI districts the contractor’s expatriate staff resigned after just a few months and needed to be replaced which has resulted in delayed implementation.

V. DISCUSSION

18. The experience thus far in Cambodia suggests that:

- Contracting for the delivery of PHC services using a competitive bidding approach is feasible and can be carried out efficiently and transparently. Extensive consultation with stakeholders is of paramount importance.
- Competitive bidding can attract sufficient competition and will likely attract more participation as the lessons from the initial experience are incorporated into future bidding procedures and potential bidders gain confidence that the risks of contracting are relatively low. Contracting for health services is an iterative process which will have to be custom fitted to country-specific conditions.
- With some initial assistance, governments can design, monitor, and manage contracts.
- Contracts can be designed that ensure that all parties focus on critically important outputs and outcomes.
- It is possible to subject contracting to rigorous evaluation, which will provide important information on the effectiveness and efficiency of various approaches.

19. The bid costs of contracting for PHC were high relative to the MOH budget but are significantly lower than was estimated by the World Bank in 1993 (5). At slightly more than $5 per capita per year there has been some concern that CO is not sustainable in Cambodia given current levels of budget allocations. It is possible that the cost will come down in future contracts if there is greater competition and as more indigenous NGOs become involved. International NGOs may have had high costs because of their expatriate staff and the desire to pay what they saw as “fair” wages. The experience in
Bangladesh, where local NGOs have bid on PHC service provision, demonstrates that the cost of contracting does not need to be as high as was found in Cambodia.

Definitive conclusions about the effectiveness and efficiency of contracting for health service delivery in Cambodia will have to wait until follow-on household and health facility surveys are carried out. However, the experience thus far has not indicated that there are any fatal flaws in the contracting for health service delivery.

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